

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA		(X3) DATE SURVEY COMPLETED C 05/16/2007
NAME OF PROVIDER OR SUPPLIER REGENT CARE CENTER OF RENO			STREET ADDRESS, CITY, STATE, ZIP CODE 555 HAMMILL LANE RENO, NV 89511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation conducted on 5/7/07 and 5/16/07. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00014971 alleged that the facility failed to provide adequate care to a resident. The complaint was substantiated. See Tags F 272 and F 333.	F 000	<i>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely due to requirements under state and federal law.</i>		
F 272 SS=G	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1. Unable to correct since incident already occurred and Resident was already discharged from facility. How you will identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken: All residents have the potential to be affected by the practice. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Staff in-service scheduled and will be on-going to discuss (1) accurate carrying out of physician orders; (2) accurate/timely assessment addressing Resident conditions (i.e., DVT, constipation) as indicated in the Resident's Plan of Care; and (3) review of facility's BM Protocol.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	<p>Continued From page 1</p> <p>Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to assess a resident who was at risk for a deep venous thrombosis and constipation. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1: The resident was admitted to the facility on 01/18/07 and transferred to an acute care facility on 4/10/07. The resident's admitting diagnoses included a fracture of the radius and ulna, aftercare of internal fixation device, osteoporosis, senile dementia, debility, and constipation.</p> <p>Resident #1's admitting orders included Lovenox 40 milligrams (mg) and aspirin 81 mg daily to prevent the development of a deep venous thrombosis (DVT). On 2/16/07 there was a physician's order to discontinue the Lovenox when the current supply was exhausted and to begin Heparin 5000 Units subcutaneous twice a day. The Heparin was initiated on 2/20/07. The Heparin therapy was discontinued on 3/27/07 without a physician's order. Cross reference Tag 333.</p>	F 272	<p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</p> <p>DON and/or designee will conduct a random, regular review on Resident's medical records to ensure Bowel Protocol is followed, appropriate assessment is done as indicated in the patient's plan of care and MD orders are carried out accurately.</p> <p>Individual Responsible:</p> <p>Director of Nursing</p> <p>Date of Completion</p> <p>June 11 2007</p> <p style="text-align: right;"><i>6/11/2007</i></p> <p style="text-align: center;">RECEIVED MAY 30 2007 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA</p>		

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F 272	<p>Continued From page 2</p> <p>Resident #1 was transferred to the hospital on 4/10/07 for an evaluation to rule out gastrointestinal bleeding. The hospital records were reviewed at the acute care facility on 5/7/07. Review of the history and physical dictated on 4/10/07, revealed in the physician's physical examination of the upper and lower extremities that "The right lower extremity is swollen. It is erythematous and slightly tender with +1 (plus one) edema. The left lower extremity has no edema, positive pulses, and decreased muscle tone." Review of the hospital discharge summary revealed that "The patient was also on initial evaluation found to have a swelling of the lower right extremity along with cellulitis. The patient was subsequently begun on Unasyn for the cellulitis and ultrasound of the lower extremity was requested." The physician also noted that "She seems to have a stress fracture distally at the tibia" of the right lower extremity. An ultrasound of the lower extremities was performed on 4/10/07 and the discharge summary of 4/21/07 indicated that "The ultrasound of the lower extremity came back positive for deep venous thrombosis."</p> <p>A procedure report revealed that on 4/10/07, Resident #1 had to be taken to the operating room to have a trapeze inferior vena cava filter placed. This was placed to prevent pulmonary embolism due to her diagnosis of DVT.</p> <p>The discharge summary, dictated on 4/21/07, revealed that Resident #1 was diagnosed with bilateral pulmonary embolisms and had to be started on intravenous heparin. It revealed that an infection along with multiple other medical conditions overwhelmed her, causing her generalized sepsis. She passed away on 4/20/07</p>	F 272	PLEASE SEE PAGES 1 & 2		6/11/2007

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F 272	<p>Continued From page 3 at the hospital.</p> <p>Review of the closed record at the facility on 5/7/07, revealed a care plan noting that Resident #1 had impaired physical mobility related to an upper extremity fracture. The approach included the following, "Monitor for s/s (signs and symptoms) of DVT (increase swelling of lower extremity, decreased or absence of peripheral pulses, etc) and notify physician and document as appropriate." The record review failed to reveal evidence in the nurse's notes, dated 3/7/07 to 4/10/07, that Resident #1 was being assessed for signs of DVT. There was no documentation of redness or swelling to the resident's legs noted in the notes, the discharge summary form, or the transfer form.</p> <p>On 5/16/07, from 10:00 AM to 11:00 AM, Resident #1's medical record was reviewed with a registered nurse unit manager. She reviewed the record and confirmed that the approach in the careplan was not being followed. She confirmed that there was a lack of assessment for deep venous thrombosis in the nurse's notes, dated 3/7/07 to 4/10/07. She also stated that the nurses are supposed to do an assessment each shift which includes checking the lower extremities for edema and abnormal peripheral pulses. There was no evidence found in the nurse's notes that this was being done.</p> <p>The hospital discharge summary of 4/21/07 also revealed that Resident #1 was constipated and several enemas had to be given to relieve the constipation.</p> <p>Resident #1's bowel movement (BM) documentation was reviewed. It revealed that the</p>	F 272	<p><i>PLEASE SEE PAGE 102</i></p>		<p><i>6/11/2007</i></p>

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F 272	<p>Continued From page 4</p> <p>resident did not have a bowel movement for six days from 2/18/07 through 2/23/04. The physician's orders indicated that the resident was to have Milk of Magnesia (MOM) every third day if the resident had no BM as needed for constipation. The resident did not receive the MOM until the sixth day, 2/23/07. The next day the record revealed the resident had a large bowel movement. The record also revealed the following:</p> <p>3/1/07 - no BM 3/2/07 - two small BM's 3/3/07 - no record 3/4/07 - small BM 3/5/07 - no BM is recorded 3/6/07 - no BM is recorded 3/7/07 - small BM 3/8/07 - no BM is recorded 3/9/07 - no BM 3/10/07 - no BM 3/11/07 - small BM 3/12/07 - no BM 3/13/07 - no BM 3/14/07 - no BM 3/15/07 - no BM 3/16/07 - one small and one medium BM</p> <p>Resident #1 did not receive the MOM on the third day of no BM as ordered by the physician during this time frame. There was no evidence found which indicated that these small bowel movements were assessed by the nurse. The record revealed that the resident had decreased fluid intake, decreased mobility and was taking Vicodin for pain. These would all be contributing factors to the resident's constipation. The medical record also revealed that the resident had poor food intake and had refused meals.</p>	F 272	<p><i>PLEASE SEE PAGES 1 & 2</i></p> <p>RECEIVED MAY 30 2007 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA</p>		<p><i>6/11/2007</i></p>

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F 272	Continued From page 5 The April record revealed that the resident had: 4/1/07 - two small bowel movements 4/2/07 - two medium bowel movements 4/3/07 - one medium and one large bowel movement 4/4/07 - no BM recorded 4/5/07 - one small and one medium BM 4/6/07 - No BM 4/7/07 - No BM 4/8/07 - No BM 4/9/07 - No BM 4/10/07 - one medium BM The record revealed that Resident #1's poor food and fluid intake continued during this time frame. The resident did not receive MOM on the third day of no bowel movement as ordered by the physician. There was no evidence found in the nurse's notes that the resident's abdomen was assessed for softness, distention, or tenderness. The nurse's notes did reveal that bowel sounds were being assessed. On 5/10/07, at 2:00 PM, a telephone interview was conducted with Resident #1's daughter. She stated that during her mother's stay at the facility she had witnessed her mother wince and moan in pain while holding her abdomen. She stated when she asked a nurse to evaluate her mother's abdominal pain the nurse just checked for bowel sounds and told her everything was fine.	F 272	PLEASE SEE PAGES 1 & 2	4/11/2007	
F 333 SS=G	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	PLEASE SEE PAGE 7	06/11/2007	

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F 333	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined that the facility failed to prevent a significant medication error for one resident. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1: The resident was admitted to the facility on 01/18/07 and transferred to an acute care facility on 4/10/07. The resident's admitting diagnoses included a fracture of the radius and ulna, aftercare of internal fixation device, osteoporosis, senile dementia, debility, and constipation.</p> <p>Resident #1's admitting orders included Lovenox 40 milligrams (mg) and aspirin 81 mg daily to prevent the development of a deep venous thrombosis (DVT). On 2/16/07 there was a physician's order to discontinue the Lovenox when the current supply was exhausted and to begin subcutaneous Heparin 5000 units twice a day. The medication administration record (MAR) revealed that the Heparin was started on 2/20/07. The MAR revealed that the Heparin was discontinued on 3/27/07.</p> <p>Review of the nurses notes dated 3/27/07, revealed that the resident's intravenous (IV) fluids had been completed and the IV line had been converted into a Heplock. The physician's orders and his notes dated 3/27/07, revealed that the resident's Heplock was to be discontinued. Review of the record failed to reveal evidence that resident's Heparin was supposed to be discontinued. Review of the nurse's notes dated 4/10/07, revealed that Resident #1 had a large</p>	F 333	<p>F333</p> <p>The facility must ensure that residents are free of any significant medical errors.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #1. Unable to correct since incident already occurred and Resident was already discharged from facility.</p> <p>How you will identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:</p> <p>All residents have the potential to be affected by the practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <p>Please refer to F272.</p> <p>How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur:</p> <p>Please refer to F272.</p> <p>Individual responsible:</p> <p>Director of Nursing Services</p> <p>Date of Completion:</p> <p>June 11, 2007</p>		<p>6/11/2007</p>

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F 333	<p>Continued From page 7</p> <p>amount of brown/coffee ground emesis and was transferred to the hospital to rule out gastro-intestinal bleeding.</p> <p>On 5/7/07 12:05 PM, the MAR, physician's orders, and resident's medical record was reviewed with the assistant director of nurses (ADON). She was asked about the findings regarding the Heplock and the Heparin on 3/27/07. The ADON did not provide any additional information to these findings.</p> <p>Review of the hospital medical record revealed that Resident #1 had an ultrasound of the lower extremities on 4/10/07 and that the testing revealed a positive deep venous thrombosis of the right lower extremity. A procedure report revealed that on 4/10/07, Resident #1 had to be taken to the operating room to have a trapeze inferior vena cava filter placed. This was placed to prevent pulmonary embolism due to her diagnosis of DVT.</p> <p>The discharge summary, dictated on 4/21/07, revealed that the resident was also diagnosed with bilateral pulmonary embolisms and had to be started on intravenous Heparin. It revealed that an infection along with multiple other medical conditions overwhelmed her, causing her generalized sepsis. She passed away on 4/20/07 at the hospital.</p>	F 333	PLEASE SEE PAGE 7		4/10/07

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